DOCUMENT RESUME

ED 080 176 PS 006 660

TITLE	[Health Delivery: Comprehensive vs. Episodic Users.]
INSTITUTION	Rockaway Health Center, Queens, N.Y.
PUB DATE	[73]
NOTE	22p.
EDRS PRICE	MF-$0.65 HC-$3.29
DESCRIPTORS	Adjustment (to Environment); *Community Health Services; *Disadvantaged Groups; Locus of Control; *Mothers; *Participant Characteristics; Personal Adjustment; *Psychological Characteristics; Self Concept; Socioeconomic Background
IDENTIFIERS	Project Pryme

ABSTRACT

A study to investigate the difference between episodic and comprehensive health care utilizers was undertaken with 196 mothers who registered their children at Project Pryme clinic. There were significant differences found between the two groups in the area of alienation and its subcatagories of normlessness, powerlessness and isolation. There were also significant differences found in socio-economic areas of income source, education and intactness of families. When the clinic patients were compared to the general population, it was found that the Project patients taken as a whole were alienated and much lower in ego strength. Discussion of these results focuses on the interplay of alienation and socio-economic factors as a cause to the existing situation of not only lack of clinic participation but also as a cause of their social plight. Possible solutions to diminish the alienation level and increase clinic participation are offered. (Author/KM)

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[HEALTH DELIVERY : COMPREHENSIVE VS. SPECIFIC ITEMS]

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CHAPTER I - INTRODUCTION

Among the countless problems which face the nation's poor today, perhaps one of the most pressing is the lack of adequate medical care. In order to alleviate this condition in some way, there has been established a Children & Youth Comprehensive Health Program throughout the country. The Children & Youth Project which served as the base of this study, Project Pryme, is located on the Rockaway peninsula in New York City. The area is euphemistically described as impoverished. Currently there is an urban renewal project underway, and due to this fact, there exist chaotic housing conditions. In addition to the deplorable living conditions, the residents are faced with a physical separation from the main urban centers of New York City due to the fact that only two bridges connect the residents to the mainland and transportation costs are, for the poor, prohibitive. Demographically, Far Rockaway contains a large segment of low socio-economic status black and Spanish families.

Project Pryme services over 4,000 youngsters of these families. Of these, 65% are black, 10% are Spanish and 22% are white. The services which are offered range from pediatric care to dental care and mental health services. All aspects of pediatrics, including neurology, orthopedic and allergy clinics are presently provided. In addition, laboratory, pharmacy, x-rays and a range of on-site ancillary facilities are available. Children in need of further work-ups and hospitalization are, in addition, provided with these. In accordance with the program's protocols, there are no fees charged to patients for services.

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One of the main goals of the project is to provide comprehensive health care. Comprehensive care entails preventative, diagnostic, as well as curative procedures involving all medical aspects for children and youth. Despite the fact that the project

is very well respected by the community, who, indeed, are involved in some of the decision making, it is estimated that fully 40% of all clinic appointments are not kept. This figure is extremely high when one realizes that in private practice only 15% of appointments are broken (Alpert, 1965).

Thus, the fact that our broken appointment rate was 2 1/2 times greater than that of private practice indicates that a large number of our patients were actually not receiving comprehensive health care. The question thus arose as to why some parents brought only on an episodic basis. This problem is not new in the field of public health, but in the past, much attention by authors has been focused on the social and economic factors which prevailed in the lives of the episodic care utilizers. Even though certain trends were uncovered, at no time were causal relationships established. Overlooked by these authors, were the possible psychological variables which might be operating that not only precluded these users from obtaining comprehensive health care but, in fact, may be partially responsible for the social and economic conditions with which these patients live.

It is generally the position of these authors that even though socio-economic variables operate to prevent patients from participating in comprehensive health, so also are psychological variables operating among these patients. Thus the hypothesis of this study is that alienation and ego strength as well as socio-economic variables interact to cause patients to underutilize health services, even when fees for services are not factors.

The variables of alienation and ego strength were selected on the Basis of their possible appropriateness to the problems of underutilization. With regard to the variable of alienation, the physical isolation experienced by the people living in this peninsula's ghettoes and their sense of powerlessness are deeply felt by those

who are consigned to ghetto living, indicate that alienation would be a factor in their everyday lives. The fact that those who are highly alienated tend to miss appointments is only one way in which this variable operates. Similiarly, the variable of ego strength which accounts for the person's ability to organize his life was considered a factor in the patient's ability to meet his appointment at the clinic.

A review of the literature immediately shows that this problem of under-utilization is by no means unique since high numbers of broken appointments are prevalent in other clinics. Greene (1967) estimated that fully 50% of children of poor parents in New York City have not been fully immunized. Doubtless, many of these parents had opportunities to avail themselves of health care.

Berger and Yerby, using New York City Department of Health figures for 1964, found a wide difference in the number of children being immunized when the sole criterion was family income. An example of what they found lies in the figures of children who are fully immunized for smallpox. The percentage of children immunized in the group where parents earned eight thousand dollars annually or more was 92.6 while the percentage for the group where the income was $1999 or less was 44.8. Thus, we see that economic factors correlate highly with health care sought. Lennon (1967) in a study conducted in Erie County, New York, found strickingly similar data for measles immunization. A United States Department of Health, Education and Welfare publication (1966) states that there is a marked difference in the behavior of the poor in relation to the middle class in regard to health care. Initially, the poor define illness differently partially because they have less accurate health information. The poor are also less inclined to take preventive measures and to delay longer in seeking medical care. When they do approach health practitioners, they are more likely to select sub-professionals or the marginal practitioners often found in their neighborhoods. It

appears that the people most in need of medical services are the ones who least often obtain them. Titmuss (1965) finds that the New York City experience is compatible with what the English have learned. The British National Health Service, after fifteen years of experience, found that the higher income groups who use the service to the fullest, receive more attention from specialists, occupy more of the beds in the better equipped and staffed hospitals, receive more elective surgery, get better maternity care, and are much more likely to seek psychiatric help. This is not true of the low income groups, especially the unskilled. These facts may occur universally, but still the ultimate question of why has not been answered.

Alpert (1968) and his associates in Children's Hospital, conducted a three year study of two selected groups of children. The first group was offered comprehensive care at the hospital while the second group continued attendance at the hospital emergency clinic. Rates and types of utilization were compared. Episodic visit rates were higher among the second group as compared to the first; while health visits were, as expected, higher for the comprehensive care group. Only demographic and social characteristics for each group were noted.

Nolan et al (1967) found that the lower socio-economic strata in a prepaid group tend to undertutlize planned services and that underclass blacks tend to rely more on acute medical services. The suggestion is made that resistance to planned services is due largely to parents being "poorly informed" about group health care.

An article by Anselm Strauss (1967) on health care patterns, life styles and "vicious cycles" as they affect the poor summarizes problems associated with underutilization and poor delivery in general. Among its assessments are that poor complain about not getting enough information; they do not know how to "beat the system", so as to obtain maximum services or gain understanding; their lives are organized

around their immediate neighborhoods, hence utilization varies inversely with distance; and poor are "present-oriented", theirs tend to be a "crisis life", thus less concerned with keeping appointments. The question derived from this article is whether, in fact, this is homogeneously or universally so among the indigent.

Elling, Whitmore and Greene (1967) found a correlation between patient participation in a clinic and the understanding of good health care. Of those who were classified good participants in the clinic, 84% presented a satisfactory understanding of good health care. However, of the low income participants, only 44% understood the concept of good health care. It was also found that the extent of formal education did not significantly affect the results. It was also established in this study that there was a significant differentiation in the self-concept of the individuals of the two groups. The low income participants had poor self-concepts and the high participants had good self-concepts. Finally, it was noted that those classified as low income participants seemed to have problems in establishing meaningful relationships and they did not demonstrate any upward mobility.

Alpert (1964) also conducted a study investigating the patients who did not keep their appointments. He found that 45% of all appointments at his clinic were broken. Having interviewed half of those patients who were classified as non keepers, he determined that 26% of them had a psychiatric diagnosis and 24% of them were in Social Class V. Each of these figures represents a significant difference from those who kept their appointments. When questioned, 23% of the appointment breakers admitted they never intended to keep their appointments, 38% claimed they forgot about the appointments, and 29% said family reasons prevented them from attending. When Francis et al (1965) investigated the problems of poor participation at her clinic, it was found that the most common reasons included a lack of transportation to the clinic and

PS 006660

and problems at home.

Morris et al (1966) measured two components of alienation, namely, powerlessness and social isolation. The population consisted of 246 Negro and white indigent mothers. They found that mothers who were more powerless or more socially isolated had received less care for their children. Another finding of interest was that within the lowest white occupational stratum, social isolation predicted care-seeking; while within the Negro group, alienation did not predict care-seeking. Further findings demonstrated that alienation correlated with more stated difficulties in reaching the clinic, distance from the facility, and other factors associated with less care-seeking. Finally, the more powerless mothers were found to be in less agreement with the statements of professionals about the purposes and potentials of well child supervision.

Gray (1967) using the Dean scale of alienation did a study using indigent Negro children as subjects. He found that those children whose mothers scored high on the alienation scale had received fewer polio immunizations.

The consensus of opinion surveyed by the authors is that comprehensive care is a viable way of meeting the medical needs of poor people. The fact is that if children receive good medical care at a young age, they will have a higher probability of good health as they mature. What has become apparent, however, is that the facilities which have been established to provide this comprehensive care were not being utilized by members of the community in as full a manner as they were proposed to achieve. The crucial issue is how to provide the care in such a manner that it will be accessible to all (Jacobs & Froh,1968; Lee, 1967; Dorsey,1970; Marston,1968; Cohn-1969). It has been estimated that if the money allocated presently were increased, the needs of each community would still not be met because somehow the elusive problem remains that certain of its people will not be serviced.

CHAPTER II - DESCRIPTION OF STUDY

The experimental population consisted of all mothers who had registered a child under two years of age at the clinic between January 1, 1970 and June 30, 1970. There were 196 mothers in this group. The criterion which was then established to determine whether these mothers had sought comprehensive medical care for their children was the number of medical procedures and laboratory screenings the child had received over an 18 month period. These procedures were as follows: three DPT immunizations, small pox immunizations, one Tine test, three polio immunizations, one measles vaccination, a urine analysis and a blood analysis. At this time the charts of all children involved in the study were reviewed and the number of procedures was tabulated. Consideration was also given to the number of lapsed appointments of each individual in order to determine if this was a contributing factor in the child's lacking the appropriate number of medical procedures. At times, it was found that the child did not have an optimal number of procedures due to prohibitive medical consideration. These subjects were deleted from the study.

Definition of the comprehensive episodic and intermediate health care utilizers is as follows. Comprehensive health care is defined operationally in this study as missing no more than two appointments and completion of no less than nine immunizations and/or laboratory screening procedures. Intermediate care is defined as missing more than 2 appointments plus completion of less than nine but more than 6 medical procedures. Finally, episodic care was defined as missing more than four appointments and completion of no more than six medical procedures.

After the determination of the three groups, letters were sent to the mothers. These letters explained that a member of the clinic would soon be visiting them to enlist their aid in a study. The interviewer went to the homes of the

subjects. English and Spanish letters and forms were utilized in order not to exclude any parent because of a language barrier.

The first scale presented to the subject was a ten item consumer satisfaction scale designed specifically for this study. The purpose of this scale was to reduce tension by providing a non-threatening stimulus to the participants.

Upon completion of the consumer scale, the Dean's Alienation Scale was then administered. The scale is comprised of 24 questions which allow the subject to indicate her feelings concerning a given statement along a five point continuum ranging from "strongly agree" to "strongly disagree". This scale had three major subscales; powerlessness, normlessness and social isolation. The powerlessness subscale measured feelings of helplessness and feelings of inability to influence the events of one's life. The normlessness subscale measured the existence of lack of norms or the presence of conflicting norms. The social isolation subscale was a measure of separateness from one's group or from the group's standards. This may be characterized by anonymity, spatial mobility, low social participation, few visits with friend and a greater measure of unemployment. The reliability coefficients of these scales were .78; .73 and .84 respectively. The overall scale has a reliability of .78 when corrected.

Dean's Scale of Alienation has been widely used in socio-medical, social and psychological research. This scale was selected for this study for the following reasons: first, the scale has proven to be a highly reliable measure of alienation; secondly, it is simple to administer since intelligence is minimized as a factor; third, it yields scores along different dimensions so that alienation can be explored as a syndrome and not a single trait.

After the completion of the alienation scale, the examiner administered the ego strength scale. This consists of 68 true or false items from the MMPI. Odd-even

reliability was found to be .76 and test-re-test reliability was found to be .72. This [illegible] was utilized in our study because of its high reliability, ease of administration and its general acceptance in the research field. Interviews were conducted in the homes of the subjects, or if this was inconvenient to them, the procedures were conducted at the clinic.

After complecion of all protocols, the results were tabulated and ststistically treated using factor analysis and chi square techniques.

Upon completion of all statistical analysis, the same study procedures were initiated with a group of thirty three high socio economic status patient of a private physician from a neighboring community. Their responses were compared with that of our clinic population and will be discussed in Chapter IV.

CHAPTER III - RESULTS

Of the 196 mothers selected to be subjects of the study, 73 were considered to be comprehensive health service utilizers, 68 were termed episodic health care users and 55 were placed in the intermediate catagory. Table #1 represents the breakdown of each of the three groups.

TABLE # 1

Response of Subjects by Degree of Utilization Groups

	Interviewed		Rejected		Not Located	
	No.	%	No.	%	No.	%
Comprehensive Group	51	70	10	14	12	16
Intermediate Group	29	53	9	16	17	31
Episodic Group	41	60	12	18	15	22

The first analysis which was performed was in regard to the ego strength as measured by the MMPI. An analysis of variance was performed in the three groups.

Tables # 2 & 3 indicate the results of this analysis:

TABLE # 2

MMPI Results

	Mean	SD
Comprehensive	37.9	10.4
Intermediate	35.5	6.0
Episodic	34.8	6.4

TABLE # 3

Analysis of Variance

Source	DF	SS	MS	F
Between	2	240.75	120.3	2.7(NS)
Within	115	4977.06	43.2	

When T tests were performed, the difference between the comprehensive group and episodic group were found to be significant at the .10 level: t=P.75. (.10=1.66).

The next variable analyzed was that of alienation. Table # 4 shows the results of that analysis.

TABLE # 4

Alienation Levels

	Mean	SD
Comprehensive	51.5	12.2
Intermediate	56.5	10.3
Episodic	59.5	10.2

F ratio = 7.26 (P < .01)

When T tests were performed it was found that a significant difference existed between the comprehensive and episodic utilizers (P < .01).

The alienation scale which was used - Dean's alienation scale - provided for three sub-catago.ies was performed. On the variable of feelings of isolation, analysis of variance provided an F ratio which was significant at the .01 level (P < .01). When T tests were performed, it was ascertained that a significant difference existed between the intermediate group and the episodic group (P < .05) and between the comprehensive group and episodic group (P < .01). Table # 5 shows these results.

TABLE # 5

Isolation Levels

	Mean	SD
Comprehensive	17.8	4.6
Intermediate	19.5	4.3
Episodic	21.6	4.3

F ratio = 9.37 - ($P < .01$)

The next variable studied was that of powerlessness. Despite the fact that the analysis of variance was not significant, there did exist a significant difference between the comprehensive and episodic groups ($P < .05$). Table # 6 shows these results.

TABLE # 6

Powerlessness Levels

	Mean	SD
Comprehensive	20.72	5.8
Intermediate	22.06	6.7
Episodic	23.15	5.6

F ratio - 2.05 (NS)

The final variable analyzed was that of normlessness. Analysis of variance produced an F ratio which was significant at the 01 level ($P < .01$), as shown in Table # 7.

TABLE # 7

Homelessness Levels

	Mean	SD
Comprehensive	12.6	4.2
Intermediate	14.9	3.1
Episodic	14.7	4.3

F ratio = 4.8498 ($P < .01$)

When T tests were performed, it was determined that a significant difference existed between the comprehensive and episodic groups at the .05 level ($P < .05$).

The final series of analyses performed were in regard to socio-economic differences. The raw data are presented in Table # 11 below.

A Chi-square analysis was used to investigate patients by source of income. Those who were receiving public assistance were compared with those not receiving public assistance. The results are listed below in Table # 8.

TABLE # 8

Analysis of Income

	χ^2	P
Comprehensive vs. Episodic	11.4	.001
Comprehensive vs. Intermediate	6.9	.01
Intermediate vs. Episodic	4.5	.05

A similar analysis was performed with regard to education in which the variable was whether the mother had completed high school. The results are shown in Table # 9.

TABLE # 9

Analysis of Education

	X^2	P
Comprehensive vs. Episodic	5.5	.05
Intermediate vs. Episodic	5.6	.05

The final analysis which was performed was in regard to whether the family was intact, i.e., whether the father was present in the home. The results are listed in Table # 10.

TABLE # 10

Analysis of Head of House

	X^2	P
Comprehensive vs. Episodic	8.05	.01
Intermediate vs. Episodic	.20	NS

TABLE # 11

UTILIZER GROUPS BY SOURCE OF INCOME, EDUCATION AND FAMILY INTACTNESS

	Not Receiving Pub. Assistance		Receiving Pub. Assistance		Mother Completed High School		Mother Did Not Com. High School		Father in the Home		Father Not in the Home	
	N	%	N	%	N	%	N	%	N	%	N	%
Comprehensive	34	79	9	21	18	50	18	50	40	78	11	22
Intermediate	12	50	12	50	15	52	14	48	15	52	14	48
Episodic	10	27	27	73	8	22	28	78	23	56	18	44

(N totals are less than the 129 patients interviewed since some of their charts failed to yield clear data on all of the variables listed above.) Chi-square in Tables 8,9, and 10 are, of course, based upon these data.)

CHAPTER IV - DISCUSSION

At the outset of this study, great difficulty was encountered by the interviewer in locating the subjects. Many of the patients had moved more than once since their initial visits to the clinic. However, 78% of the subjects were contacted by the end of the study.

Ego strength as measured by the M.M.P.I. did not show significant difference between the comprehensive and episodic groups ($P < .10$). However, all three groups scored significantly lower than the general population. The average response on our sample population was 17-20 points below the norm of the general population. The fact that the means between the various groups of utilizers were very close together did not allow for differentiation in care-seeking on the basis of this instrument. The finding that the clinic group has lower ego strength than the general population remains a factor to be contended with in future research. However, it appears to have little predictive value in care-seeking.

The authors felt that an explanation of the degree of utilization lies partially in the area of alienation. The overall feeling of alienation significantly differentiated the comprehensive from the episodic group ($P < .01$). In the episodic group the feeling of oppression and despair towards the outside world was very high. What was surprising, however, was the fact that all three groups exhibited very high alienation levels, although to differing degrees. When the scores of all three groups were

compared with scores of private patients of a much higher socio-economic standing, it was found that the clinic patients were significantly higher in alienation.[1] This level of alienation has long been discussed as both a cause and effect of ghetto life. The daily life experiences of ghetto inhabitants involving poverty, crime and other frustrations can be pointed to as part of the root cause of alienation. However, as the results have indicated, there are differing amounts of alienation present. For some it is not a crippling experience, while others are unable to function in a healthy manner. Regarding the expression of alienation as it pertained to our clinic, it is at least plausible to deduce that the episodic care group's feelings of despair and hopelessness manifests itself by a lack of effort to have proper medical care for their children.

Past studies on the question of proper medical care have not adequately focused their attention on the reasons for the existence of factors which preclude patients from receiving proper medical care. In our investigation of the high alienation level of our episodic care population, we were able to determine some

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1. At the suggestion of the authors, a separate procedure was undertaken to interview, analyse and compare the results of the alienation scales achieved by the clinic patients with 35 patients who were being seen by a private physician. As related above, these patients were of high socio-economic status and resided just outside the borders of the Rockaway peninsula, in a somewhat geographic isolated suburban setting.

psycho-social difficulties that existed side by side with their socio-economic difficulties. Each component of alienation, namely powerlessness, normlessness and isolation differentiated the groups as markedly as did the socio-economic variables. It seems appropriate that these variables be discussed together. To question which of the variables operate to reinforce the others seems to be futile, rather we must view them as an interplay. Economically, the episodic care group has a much higher proportion of welfare recipients then the comprehensive group. Coupled with this, the feelings of powerlessness of the former are also higher. This group is unable to adequately subsist without public subsidy, and this reality is quite apparent to them. A similar pattern also exists in the area of normlessness. A significantly higher number of patients in the episodic care group did not finish high school and also shows a differing pattern in adherence to norms and confusion of norms. It is obvious that societal norms were not followed in pursuing an education. These two factors, however, may also become a consideration in the previous discussion of

1. Cont'd

TABLE # 12

Comparision of Alienation Levels of Clinic Patients vs. Private Physician's Patients

	Private Physician		Clinic		P
	Mean	SD	Mean	SD	
Alienation	39	6.4	55.6	11.1	.01
Isolation	14.1	2.2	20.4	4.4	.01
Powerlessness	14.4	3.4	21.4	6.4	.01
Normlessness	11.2	4.1	14.0	13.9	.01

powerlessness and economic status. Isolation as it exists in its physical aspects in the area under study, greatly contributes to the feeling of social isolation that is present in the episodic care group.

It is extremely difficult to move around the peninsula without transportation, and it is very time consuming as well as expensive to leave the peninsula. Thus, the isolation which is felt in terms of physical reality is also present in terms of social reality. Relatively little social interplay exists which can be quite limiting and debilitating.

The question now remains as to how to enter this situation and to help remove some of the feelings of alienation as they relate to use of clinic services. Past studies have looked at the socio-economic conditions and called for massive socio-economic changes to remedy the situation. This, we feel, is beyond our sphere of influence. Calls for changes in ghetto life have been heard for years and yet they remain. We must look at our own clinic situation and see what we can do. Since, as was stated at the outset, the causes of poverty and feelings of alienation they engender are intermingled, and since we must admit to our inadequacy in removing ghetto

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(Cont'd)

1. As Table # 12 indicates, alienation in general as expected among these well attending, higher status patients was lower. It maybe of interest to note, however, the finding that the level of normlessness of the private physician group was closer to that of the clinic population than the factors of isolation and powerlessness.

conditions, one of our few alternatives must reside in dealing with the phenomenon of alienation. One of the methods which has succeeded in individual cases is through interpersonal contact. Alienation will tend to decrease, we feel, when the individual sees for himself that others are generally concerned for one's welfare, or in the present case, concerned for one's medical well being. One possible approach may be via personal contact with trained indigenous paraprofessionals from the clinic to teach certain fundamentals in child care to parents. Also, by forming small groups which may be led by these same paraprofessionals to discuss problems which arise for parents in raising their children. By these personal contacts in local homes or in the clinic, perhaps the individuals will begin to perceive that the clinic is concerned about them. Individual efforts have more of a chance of success when the alienated are at home in their own environment than it does when they are coming to the clinic on an emergency or episodic care basis.

Another method of approach would lie in the encouragement of the community to be involved in certain decision-making matters outside of medical decisions per se. Through this, it is thought that community members will have a greater feeling of participation and consequently, an increased feeling that it is their clinic in many respects.

Naturally each clinic setting is different with its own uniqueness. However, it would seem that our finding of high alienation existing in the population of poverty areas is not unique. As such, before the medical needs of a community can be met, this alienation of its inhabitants must be recognized and adequately dealt with.

CHAPTER V - SUMMARY

A study to investigate the difference between episodic and comprehensive health care utilizers was undertaken with 196 mothers who registered their children at Project Pryme clinic. There were significant differences ($P < .01$) found between the two groups in the area of alienation and its subcatagories of normlessness, powerlessness and isolation. There were also significant differences found in socio-economic areas of income source, education and intactness of families ($P < .01$). When the clinic patients were compared to the general population, it was found that the Project patients taken as a whole were more alienated ($P < .01$) and much lower in ego strength. Discussion of these results focused on the interplay of alienation and socio-economic factors as a cause to the existing situation of not only lack of clinic participation but also as a cause of their social plight. Possible solutions to diminish the alienation level and increasing clinic participation were offered.

Implications: In addressing itself to the assessment of various factors which tend to lead to a reduced ability to avail one's self of freely offered health services, the study's findings may also be applied to similar problems in areas other than the delivery of health care to children. This might include the provision of social services, mental health care, education, etc.

Additionally, the study unearthed a number of pertinent and reactive variables such as alienation and ego strength. This may enable one-with further statistical treatment of the findings-to predict for whom and along what lines efforts can be made to reduce alienation and to increase the utilization levels of its health care and similar services to a more ordinate extent.

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